Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID
PROVIDER MANUAL
UPDATE

TO: All Physician Providers participating in the Virginia Medical Assistance Program, Managed Care Organizations providing services to Virginia Medicaid recipients, and all holders of the *Physician* Provider Manual.

UPDATE: R-Phys-PA

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

DATE: 06/13/2006

SUBJECT: Update to the *Physician* Provider Manual

The purpose of this memorandum is to notify you of changes to Chapter IV, V, and Appendix D as well as the inclusion of a new Appendix (Appendix F -- Primary Care Assoc. Clinics) of your Physician Manual. The attached table shows the changes to the Provider Manual. Please download the new pages to insert into your Provider Manual and retain the attached table.

The amendments to Chapter IV (Covered Services) include: (i) information on services covered under the Family Planning Waiver, as well as billing procedures; (ii) information on physician assistants; (iii) updated information on hospital inpatient pre-authorization; (iv) information on telemedicine services; (v) an update on pap smear section; (vi) updates on billing procedures for newborn screening test kits; (vii) an update on HMO copayments, and (viii) an update on the appeal process.

The amendments to Chapter V (Billing Instructions) include: (i) an update on other insurance guidelines; (ii) an update on automated crossover claims processing; (iii) a new section on non-emergency, outpatient MRI, CAT and PET scans prior authorization process; (iv) information on the negative balance process; (v) information on telemedicine billing, and (vi) instructions on family planning waiver billing.

The Amendments to Appendix D (Procedure Codes Requiring Pre-Authorization by DMAS Medical Support) include guidelines regarding prior authorization under DMAS' new prior authorization contractor, KePRO.

The new Appendix F combines previously available information regarding Federally Qualified Health Clinics (FQHCs), and includes a description of the available primary care association clinics. These changes were effective June 5, 2006. Please review this information carefully.

KePRO IS THE NEW DMAS CONTRACTOR

KePRO is an innovative healthcare management solution company that conducts prior authorization (PA) for Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus clients in the fee-for-service programs. While KePRO is now DMAS' PA agent, DMAS will process any appeals and pended cases that were submitted to DMAS on or before May 21, 2006.

CHANGES IN SERVICES LIMITS AND PA CRITERIA REGARDING BEHAVIORAL HEALTH

As noted in previous communications, DMAS increased the services limits for outpatient psychiatric services from five visits to 26 visits in the first treatment year, as of May 22, 2006. After the initial 26 visits, preauthorization is required. Final determinations are made using InterQual Behavioral Health Criteria with supplemental questions, as determined by regulations where InterQual does not specifically meet DMAS' Outpatient Psychiatric Service criteria. Training is being be provided by KePRO regarding their PA process. Please plan on attending one of the trainings identified in upcoming Medicaid Memoranda.

KePRO's hours of operation are from 8:00 a.m. to 7:00 p.m., Monday through Friday, EST (except on some state holidays). The information you are required to submit for the PA is identified in the *Psychiatric Services Manual* and the *Mental Health Clinic Manual.* Attached to this memorandum is the Outpatient Prior Authorization Request form used to identify critical information to process the request for service.

KePRO CONTACT INFORMATION

KePRO accepts requests for PA via iExchange (direct data entry through the web), fax, mail, or phone. The preferred method for requesting PA for Outpatient Psychiatric Services is through iExchange.

To submit requests via iExchange, log on to DMAS.KePRO.org and register for a provider web account. You must have a provider web account before submitting information through iExchange. To register for a web account, you must know your Medicaid provider number and tax identification number.

To submit requests via phone, fax, or mail you may submit your requests to:

KePRO

Toll Free Phone: 1-888-VAPAUTH (1-888-827-2884)

Local Phone: (804) 497-1333

Fax: 1-877-OKBYFAX (1-877-652-9329)

2810 N. Parham Road, Suite 305

Richmond, VA 23294

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-provider_newletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

PHYSICIAN PROVIDER MANUAL
REVISION CHART
JUNE 13, 2006

SUMMARY OF REVISIONS

MANUAL SECTION	MATERIAL REVISED	NEW PAGE NUMBER (S)	REVISED PAGE(S)	REVISION DATE
Chapter IV (Covered Services)				06-05-2006
Chapter V (Billing Instructs.)				06-05-2006
Appendix D (PA/PA Codes)				06-05-2006
Appendix F (PC Assoc. Clinics)				06-05-2006

FILING INSTRUCTIONS

MANUAL SECTION	DISCARD	INSERT	OTHER INSTRUCTIONS
Chapter IV	Old Chapter IV	New Chapter IV	
Chapter V	Old Chapter V	New Chapter V	
Appendix D	Old Appendix D	New Appendix D	
Appendix F	N/A	New Appendix F	

Outpatient Prior Authorization Request Form

DMAS/KePRO

Submit fax request for prior authorization to: 1-877–OKBYFAX (877-652-9329)
Requests may be submitted up to 30 days prior to scheduled procedures/services, provided Enrollee is eligible.

Recert: Enter previous PA#. Change or Cancel: enter PA# to be changed or canceled.

1. ☐ Initial ☐ Recertification ☐ Change ☐ Cancel PA #_____

2. Date of Request: (mm/dd/yyyy) ____/____/_____	**3. Review Type: (Please check one)** ☐ Retrospective Prepayment Review (Date notified of eligibility ____/____/_____) ☐ Retroactive MCO disenrollment			
4. Enrollee Medicaid ID Number (12 Digit number):	**5. Enrollee Last Name:**	**6. Enrollee First Name:**	**7. Date of Birth: (mm/dd/yyyy)** ____/____/_____	**8. Sex:** ☐ **Male** ☐ **Female**

9. Requesting/Service Provider Name and Medicaid ID Number/NPI:	**10. Treatment Setting:** ☐ **Outpatient** ☐ **Provider's Office** ☐ **Home** ☐ **Intensive Outpatient**	11. Primary Diagnosis Code/Description: (enter up to 5) **1.** _____ _____ **2.** _____ _____ **3.** _____ _____ **4.** _____ _____ **5.** _____ _____

12. Referring Provider Name and Medicaid ID Number/NPI:	**13. PA Service Type:** ☐ **0050 Outpatient Psych** ☐ **0092 Orthotics (EPSDT)** ☐ **0100 DME** ☐ **0204 Outpatient Rehab** ☐ **0450 MRI** ☐ **0451 CAT** ☐ **0452 PET** ☐ **0500 Home Health**

14. Severity of Illness (See instructions pertaining to each service types, clinical indicators of illness including abnormal findings):

15. Intensity of Services (See instructions pertaining to each service types, proposed/actual monitoring and therapeutic services, plan of treatment, goals of treatment):

16. Additional Comments (See instructions pertaining to each service type, axis):

Outpatient Prior Authorization Request Form

DMAS/KePRO

Number	17. HCPCS/ CPT/ Revenue Code	18. Code Description	19. Modifiers (if applicable)	20. Units Requested	21. Actual Cost per Unit	22. Frequency	23. Total Dollar Requested	***24. Dates of Service***	
								From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.								___/___/_____	___/___/_____
2.								___/___/_____	___/___/_____
3.								___/___/_____	___/___/_____
4.								___/___/_____	___/___/_____
5.								___/___/_____	___/___/_____
6.								___/___/_____	___/___/_____
7.								___/___/_____	___/___/_____
8.								___/___/_____	___/___/_____
9.								___/___/_____	___/___/_____
10.								___/___/_____	___/___/_____
11.								___/___/_____	___/___/_____
12.								___/___/_____	___/___/_____
13.								___/___/_____	___/___/_____
14.								___/___/_____	___/___/_____
15.								___/___/_____	___/___/_____
16.								___/___/_____	___/___/_____
17.								___/___/_____	___/___/_____
18.								___/___/_____	___/___/_____

25. Contact Name: _____

26. Contact Telephone Number: _____

27. Contact Fax Number: _____

Outpatient Prior Authorization Request Form

DMAS/KePRO

Additional Information

14. Severity of Illness:
15. Intensity of Services:
16. Additional Comments:

INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

This FAX submission form is required for outpatient Prior Authorization Review, Concurrent Review and Retrospective Review. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on KePRO forms can be entered. Do **not** send attachments or non-KePRO forms.

If KePRO determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by the DMAS Fiscal Agent will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iEXCHANGE (http://dmas.kepro.org) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous preauthorization would be a recertification request.
   - **Change**: a change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one preauthorization number. An example of canceling all lines is when an authorization is requested under the wrong enrollee number.
2. **Date of Request:** The date you are submitting the prior authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Retrospective review policy and procedure for each service detailed information regarding the submission of a Retrospective Review request. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Enrollee Medicaid ID Number:** It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.
5. **Enrollee Last Name:** Enter the enrollee's last name exactly as it appears on the Medicaid card.
6. **Enrollee First Name:** Enter the enrollee's first name exactly as it appears on the Medicaid card.

7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Sex:** Please place a √ or **X** to indicate the sex of the patient.
9. **Requesting/Service Provider Name and Medicaid ID Number/NPI:** Enter the requesting/service provider name and Medicaid ID number or national provider identifier.
10. **Treatment Setting:** Place a √ or **X** to indicate the place of service.
11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and description indicating the reason for service(s). You can enter up to 5 descriptions and ICD-9 codes.
12. **Referring Provider Name and Medicaid ID Number/NPI:** Enter the referring provider name and Medicaid ID number or national provider identifier for the provider requesting the service.
13. **PA Service Type:** Place a √ or **X** to indicate the category of service you are requesting. Orthotics: If enrollee is under 21 check "Orthotics (EPSDT)".
14. Severity of Illness (Clinical indicators of illness including abnormal findings)*:

- **One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.**
- **Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions/% as appropriate]).**
- **Service Type specific instructions:**

Outpatient psych	**List all symptoms and behaviors supporting the need for outpatient psychiatric treatment. Clinical documentation should address safety risks (immediate or potential), level of functioning, adequacy of support system and social factors. For continued treatment, include clinical findings within the last five visits and progress towards treatment goals. Clinical updates should describe treatment compliance and any related changes to the individual's psychosocial and medical status.**
DME	**Provide all of the information listed in Section II of the CMN.**
Home Health - Rehab	**Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.**
Home Health – Skilled Nursing	**Describe specific orders for nursing.**
Rehab	**Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.**

15. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:**

- This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
- This field must include the treatment plan for the patient. List the services, procedures, or treatments that will be provided to the patient.
- **Service Type specific instructions:**

Outpatient psych	**Identify the treatment modality (i.e. individual, family, or group), number and frequency of sessions and anticipated duration of treatment.**
DME	**Provide all of the information listed for each line item in Section III and IV of the CMN. Include all items and not only those that require preauthorization. (If there is no begin service date, list the physician's signature date that is on the backside of CMN.)**
Home Health - Rehab	**Describe long term and short term goals with achievement dates.**
Home Health – Skilled Nursing	**Specific description of goals and achievement dates; Specific description of procedures, especially if requesting comprehensive visits; If requesting ongoing comprehensive visits, specify why goals have not been accomplished.**
Rehab	**Identify if the plan of care is a 60-day plan of care (acute) or an annual plan of care (non-acute); Describe the long term and short term goals with achievement dates; Documentation of meeting program goals.**

16. **Additional Comments** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the regulations, DMAS manual, and InterQual criteria (see PA chapter in the DMAS manual).

Outpatient psych	**Confirm: psychosocial assessment completed; substance abuse and/or medication evaluations completed (if needed); and plan of care designed, signed, and dated by a Licensed Mental Health Provider (LMHP). Indicate where the service is being provided (Mental Health Clinic, provider's office, home, or nursing home).**

17. **HCPCS/CPT/Revenue Code:** Provide the HCPCS/CPT/Revenue procedure code.
18. **Code Description:** Provide the HCPCS/CPT/Revenue procedure code description. For NEOP, provide the type of scan and location.
19. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Supplies Listing/Appendix B found in the DMAS DME provider manual information.
20. **Units Requested**: Based on physician's orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of InterQual/DMAS criteria will be extremely helpful.

DME providers: Only identify the number of units necessary in excess of the established allowable for the time span requested. For example, if 2 cases of diapers are allowed per month and 3 cases are used per month, the overage is 1 case per month. If a timeframe of 6 months is requested by the From and Thru date, then the total Units Requested for the time frame is 6 cases. Place numbers only in the Units Requested block. Units requested as 2/2 months or 100/box/month or 7 days cannot be keyed and will be rejected.

21. **Actual Cost per Unit or Usual and Customary (DME providers only)**: Enter information in this column for codes identified in Appendix B as individual consideration (IC) or usual and customary. For IC, enter actual cost per unit less any incentives/discounts or reductions received from the manufacturer. For items identified in Appendix B as usual and customary, enter the provider's usual and customary charge to the generic public. The provider must retain documentation supporting this dollar amount.
22. **Frequency**: Enter the frequency of the visits/service from the physician's order, plan of care or CMN. Not necessary for DME if included under Intensity of Service.
23. **Total Dollars Requested**: Enter the dollar amount requested for items listed as usual and customary or IC in the appendix B. In the Appendix B, each code is listed with a set fee, as usual and customary or IC. The Total Dollars Requested is the total for all units requested in that line. For items listed as usual and customary enter your usual and customary charge to the general public and attach verification of this charge, such as your company's price list or invoice. For items listed as IC enter the dollar amount requested. The provider must retain documentation supporting verification of cost (a manufacturer's invoice, brochure with cost information from the manufacturer, cost estimate on letterhead from the manufacturer, etc.) This cost is per unit of the item being requested, e.g. 1ea, 1 pair, or 1 box of 100.
24. **Dates of Service**: Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
25. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
26. **Contact Phone Number**: Enter the phone number with area code of the contact name.
27. **Contact Fax Number**: Enter the fax number with the area code to respond if there is a denial/reject.

****Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.***

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the enrollee's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.